SHIP Volunteers
Volunteer Application

Name: _____ Phone: _____

Address: _____ Date of Birth: _____

_____

I am willing to volunteer in the following capacities: (check all that apply)

_____ Prescription assistance from home
_____ Prescription assistance at Senior Center
_____ Prescription assistance at GRADD
_____ Providing Transportation
_____ Being available at a local senior center
For SHIP counseling
_____ In home visits to assist hearing
And vision impaired with
General SHIP information

Do you have extensive knowledge of any of the following programs: (check all that apply)
_____ Medicare
_____ Medicaid
_____ Medigap Policies (Supplemental Policies)
_____ Veterans Benefits
_____ Social Security
_____ Social Security Insurance
_____ Long Term Care Insurance
_____ Food Stamps
_____ Prescription Assistance
_____ Other
Please specify: _____

_____

Please circle the days of the week and write the times you would prefer to volunteer:

M T W TH F Sat. Sun.

_____ _____

_____ _____

_____ _____

Please list your educational background and any experience that you believe will assist you in your volunteer work with this program:

_____

_____

_____

Please list three (3) references:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Name: _____

Address: _____

_____

Phone: _____

Date: _____ Signed: _____

For office use only

Date Interviewed: _____ Start Date: _____

Training Completed: _____ Record Check: _____

Recommendations: _____